Adolescent Family Life Program/Cal-Learn
Comprehensive Baseline Assessment

Intake Date_____/____/_____ CMC Code_____
Client I.D. #_____ Client SS#_____

Part I
DEMOGRAPHICS

1. Demographics

Client Name:_____Age:_____ DOB:_____/_____/_____POB:_____
First MI Last
Address:_____ City:_____ Zip:_____

Mailing Address, if different_____ City: _____Zip:_____

Home Phone:_____ Message Phone/Pager:_____ Sex: [ ] F [ ] M Marital Status:_____

Ethnicity: Latino Origin:

	Client	Household
Primary Language		
English	Speak [ ] N [ ] Y Read [ ] N [ ] Y Write [ ] N [ ] Y	Speak [ ] N [ ] Y Read [ ] N [ ] Y Write [ ] N [ ] Y
Interpreter Needed	[ ] N [ ] Y	[ ] N [ ] Y

Emergency Contact:_____Relationship to Client:_____
Phone: Address:

List below individuals who live in the home with the Client:

Name	Relationship	Age	Last Contact	Involvement

Other individuals whom the client considers a part of her/his support system:	Relationship	Age	Lives with client?	Last Contact	Involvement

Type of Housing_____# of times moved within last 6 months_____ Time at this residence_____
List name and address(es) (if different from client's):
Biological Mother: _____City_____State_____ Zip_____
Biological Father:_____City_____State_____ Zip_____
Legal Guardian: _____City_____State_____Zip_____

Part II
HEALTH, NUTRITION, FAMILY PLANNING

2. General Health

Medical Insurance Plan:_____Provider: _____
First Last

Address:_____Phone:_____

Client's Medical History/Problems/Concerns: _____

_____

Receiving Treatment? [ ] No [ ] Yes Date of last physical exam: ____/_____/____

Hospitalizations/ER: [ ] No [ ] Yes If yes, When and for what?_____

Immunizations Current? [ ] No [ ] Yes [ ] U/K If no, reason:_____(Complete IZ Form)

Significant Family Medical Concerns (Past or Current): _____

_____

Dental Insurance Plan: _____ Dentist: _____
First Last

Address: _____ Phone: _____

Date of last dental visit: ___/___/___ Comments: _____

3. Nutrition

PREGNANT CLIENT ONLY

Pre-pregnant weight:_____# Expected Wt. Gain:_____# Cravings for any of the following? Cornstarch Laundry Starch Plaster Dirt Clay Ice

Had any of the following: Nausea Vomiting Constipation Diarrhea

Feeding method planned for index child, if appropriate: Breast Formula Both Undecided

ASK ALL CLIENTS

Current Weight:_____# Currently dieting? [ ] No [ ] Yes Past history of diets? [ ] No [ ] Yes If yes, explain: _____

Meals usually eaten: Breakfast AM Snack Lunch Snack Dinner PM Snack Other_____

Foods usually eaten each day: Meats Dairy Breads/Cereals/Grain Fruit Vegetables

Beverages usually consumed each day: Milk Fruit Juice Water Soda Sweetened drinks Wine Beer Coffee Tea

Other_____ Estimate # of 8 oz. glasses of water consumed each day:_____

WIC: [ ] Eligible [ ] Enrolled Next appointment: ___/___/___ Location of WIC services: _____

Vitamin/Mineral Supplements taken:_____ Other medications currently taking:_____

Home or cultural remedies used when ill? [ ] No [ ] Yes Have you told your MD? [ ] No [ ] Yes

4. Family Planning Services

Past Type:_____ Success: _____

Present Type: _____ Success: _____

Feelings--Client:: _____

Partner: _____

Education: _____Provider:_____

PART III
Pregnancy, Labor, Birth and Postpartum

5. Pregnant Client ONLY

Feelings/Concerns/Medical problems associated with this pregnancy:_____

Current pregnancy planned: [ ] No [ ] Yes FOB Supportive? [ ] No [ ] Yes

High-Risk Pregnancy Issues: (Circle all that apply)
Headaches Puffiness Abdominal Cramping Excessive thirst Blurred Vision Vaginal Bleeding or Discharge Excessive Tiredness

EDC (Due Date):_____/_____/_____ Month MD Care Began _____/_____

Medical Provider: _____

Address:_____Phone:_____

Date last seen: ___/___/___ Next appointment: ___/___/___

Problems accessing prenatal care:_____

Planned Birthing Location:_____

Client's parents' feelings about this pregnancy and their degree of involvement with the client/child:
_____

Who will be present at the birth?_____

Prenatal Education Needs: _____

Postpartum Education/Issues: _____

6. Postpartum Health Assessment **(COMPLETE IF BIRTH WITHIN THE LAST 3 MONTHS)**

Delivery Date: ___/___/___ Date of first exam following birth: ___/___/___ Date of last physical exam: ____/_____/____

Type of Birth: Vaginal C-Section Complications: _____

Postpartum Issues/Concerns: (Circle all that apply)

Abdominal Cramping Elimination Problems Vaginal bleeding or discharge Excessive tiredness Wt. Gain/loss

Breast Care: Engorgement Cracked Nipples Soreness

7. Pregnancy History--Ask All Clients

Total # Pregnancies _____	Live Births	Miscarriages	Other
Dates of Occurrence:			

Feelings about previous pregnancy outcomes: _____

_____

Previous pregnancy planned: [ ] No [ ] Yes FOB Supportive? [ ] No [ ] Yes

Do you think you might be pregnant now? [ ] No [ ] Yes If yes, explain: _____

Client's parents' feelings about previous pregnancy(ies) and their degree of involvement with the client/child:
_____

Part IV
EDUCATION, EMPLOYMENT, PARTNER(S)

8. Education/Vocation

Enrolled in School ? [ ] No [ ] Yes Where:_____

Grade or Program:_____

Days Attending	Monday	Tuesday	Wednesday	Thursday	Friday
Hours Attending					

Unique Educational Needs: Speech ESL Hearing Vision Problems with reading/writing Learning disability/problem

Do you feel safe at school? [ ] No [ ] Yes [ ] Not enrolled/Not attending

Reason not enrolled or not attending:

_____

How well are you doing in school? _____

Feelings about school: _____

Previous School Attended:_____Last Grade Completed:_____

If dropped out, date:_____/_____/_____

Reason:_____

# of credits earned toward a high school diploma: _____ or [ ] U/K

# of GED tests already passed, if applicable: _____ or [ ] U/K

9. Employment/Job Training

Legally emancipated Minor: [ ] No [ ] Yes Date: ___/___/___ Seeking employment: [ ] No [ ] Yes

Currently Employed: [ ] No [ ] Yes Current Employer:_____

If under 16, do you have a work permit? [ ] No [ ] Yes

Current Job Training/ROP:_____

Days Working	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Hours Worked							

Length of time on the job:_____ Previous Employer/Experience/Training: _____

_____

10. Father of Index Child

Relationship with FOB: [ ] Involved [ ] Stable [ ] Unstable [ ] Uninvolved Length of Relationship: _____

Are there safety issues with the FOB [ ] No [ ] Yes Comments:_____

Name: _____ Age: ____ Ethnicity: _____ Phone: _____

Address:_____ City: _____ State: ____Zip:_____

Last grade in school completed: _____ Currently enrolled? [ ] No [ ] Yes Employed: [ ] No [ ] Yes

Where:_____

FOB at risk for Gang Involvement? [ ] No [ ] Yes [ ] U/K Comments:_____

Legal involvement with juvenile hall and/or adult legal history? [ ] No [ ] Yes [ ] U/K Comments: _____

_____

FOB's Feelings/Concerns associated with this pregnancy/relationship:

_____

FOB parents' feelings about this pregnancy and /or their degree of involvement with the client/child:

_____

11. Current Partner, If Different From Father of Index Child

Relationship with current partner: [ ] Involved [ ] Stable [ ] Unstable [ ] Uninvolved Length of Relationship: _____

Are there safety issues with the current partner? [ ] No [ ] Yes Comments:_____

Name: _____ Age: ____ Ethnicity: _____ Phone: _____

Address:_____ City: _____ State: ____Zip:_____

Last grade in school completed: _____Currently enrolled? [ ] No [ ] Yes Employed: [ ] No [ ] Yes Where:_____

At risk for Gang Involvement? [ ] No [ ] Yes [ ] U/K Comments:_____

Legal involvement with juvenile hall or adult legal history? [ ] No [ ] Yes [ ] U/K Comments:_____

_____

Current partner's Feelings/Concerns associated with this pregnancy/relationship:

_____

PART V
BASIC NEEDS, FINANCIAL, LEGAL, MENTAL HEALTH, DRUG HISTORY

12. Basic Needs

Item	Adequate	Intermittent	Inadequate
Food			
Cooking Facilities			
Refrigeration			
Water			
Heat			
Electricity			
Housing			
Transportation			
Other:_____			

13. Financial

Support	No	Yes	Needed	Comments
AFDC (Payee)				EW Name/Code--
AFDC (Nested)				Payee's Name--
Court/County Supported				
Social Security/SSI				
MediCal for Self				
MediCal for Baby Only				
Other				
Child Support Payments				
Food Stamps				
General Financial Support				

14. Drug and Alcohol History

Drug	Age of first use	Last Use	Current Use (w/in last month)	Amount	Comments
Alcohol					
Marijuana					
Cocaine Crack					
Meth (crank)					
Hallucinogens					
Tranquilizers					
Inhalants					
Prescription /OTC					
Tobacco/2nd hand exposure?[ ] N [ ] Y					
Other					

Treatment History: [ ] No [ ] Yes Dates: _____

In what situations do you use drugs/alcohol? _____

_____

If pregnant, have you used drugs/alcohol/tobacco during this pregnancy? [ ] No [ ] Yes When?_____

Does/did current partner use drugs or alcohol? [ ] No [ ] Yes What? _____

Does/did anyone in your family use drugs or alcohol? [ ] No [ ] Yes Who?_____What?_____

How much/how frequently? _____

Have any of your family members, FOB, or current partner ever been in treatment for drug/alcohol abuse? [ ] No [ ] Yes

Who?_____Treatment dates: _____

Comments:_____

15. History of Legal Involvement

Is client on probation? [ ] No [ ] Yes Probation Officer's Name _____

Summary:_____

_____

16. Mental Health History

Counseling: [ ] No [ ] Yes Dates:_____

Suicide Attempts/Ideation: [ ] No [ ] Yes Dates: _____

Contract with Case Manager not to Harm Self: [ ] No [ ] Yes Comment: _____

Psychiatric Treatment: [ ] No [ ] Yes Dates:_____

Inpatient Treatment: [ ] No [ ] Yes Dates:_____

Diagnosis:_____

Physician: _____

Outpatient Treatment: [ ] No [ ] Yes Dates:_____

Psychiatrist/Therapist: _____

Comments: _____

_____

_____

_____

_____

Part V
Safety/Violence/Abuse

17. Environment

Do you feel safe in your neighborhood? [ ] No [ ] Yes If no, why?_____

Do you feel safe in your home? [ ] No [ ] Yes If no, why? _____

Do you feel safe with your family? [ ] No [ ] Yes If no, why? _____

Have you ever runaway? [ ] No [ ] Yes If yes, why? _____

Have you ever been homeless? [ ] No [ ] Yes When and why? _____

18. Gang Involvement/ Dating Violence

Are you a member of a gang? [ ] No [ ] Yes If yes, which one? _____

Is anyone in your family a member of a gang? [ ] No [ ] Yes If yes, who? _____

Have you ever been hurt by an intimate partner? [ ] No [ ] Yes If yes, when and what happened?_____

_____

Was medical treatment required or received? [ ] No [ ] Yes

Other intervention required or received? [ ] No [ ] Yes

Was law enforcement involved? [ ] No [ ] Yes

Have **YOU ever hurt** your intimate partner, a member of your family or any other person? [ ] No [ ] Yes

Was medical treatment required or received?[ ] No [ ] Yes

Other intervention required or received? [ ] No [ ] Yes

Was law enforcement involved? [ ] No [ ] Yes

19. Abuse

Have you ever experienced any of the following: Reported to CPS/Law enforcement?

Physical Abuse: [ ] No [ ] Yes Date(s): _____ [ ] No [ ] Yes

By Whom: _____

Sexual Abuse: [ ] No [ ] Yes Date(s): _____ [ ] No [ ] Yes

By Whom: _____

Emotional Abuse: [ ] No [ ] Yes Date(s): _____ [ ] No [ ] Yes

By Whom: _____

Abusive Relationships: [ ] No [ ] Yes Date(s): _____ [ ] No [ ] Yes

By Whom: _____

Age Disparity between FOB/Current Partner and Client:_____(Number of years)
Mandated Report Required? [ ] No [ ] Yes

Part VII
Index Child

20. Basic Data

Full Name	DOB	Sex	Birth Wt.	Birth Length	Current Wt	Current Height	Birth Site

Caregiver(s) other than client: _____

21. Health

Medical Insurance Plan:_____ Pediatrician:_____
First Last
Address:_____Phone:_____

Last provider visit: ___/___/___ Well or Sick Next Visit: ___/___/___ Hospitalizations/ER: _____

Current Medical Problems:_____

Current Medications: _____Immunizations Current? [ ] No [ ] Yes [ ] U/K If no,

Reason:_____ (Complete IZ form)

Significant Past Illnesses: _____ Congenital Defects: _____

22. Nutrition

If breast feeding, frequency_____ How long do you plan to breastfeed: _____

Problems breastfeeding: _____

If formula feeding, type: _____ Amount: _____ Frequency: _____

Vitamins: [ ] No [ ] Yes Fluoride: [ ] No [ ] Yes

Other food intake, circle all that apply: Breads/Cereal Meat Dairy Fruit Vegetables Other: _____

WIC: [ ] Eligible [ ] Enrolled Next appointment: ___/___/___ Location of WIC services: _____

Feeding Problems: _____

Elimination Problems: _____

23. Developmental Screening

Age	Milestone	Observed to be in Normal Limits	Referral Needed
2 months	smiles responsively		[ ] No [ ] Yes
6 months	rolls over and reaches for a toy		[ ] No [ ] Yes
9 months	feeds self finger food, stands holding on, sits with no support		[ ] No [ ] Yes
12 months	plays patty cake, mama-dada non-specific, pulls to stand		[ ] No [ ] Yes
15 months	stands alone, mama/dada specific, waves bye-bye		[ ] No [ ] Yes
18 months	drinks from cup, two word vocabulary, walks well		[ ] No [ ] Yes
24 months	kicks a ball, walks up steps, 6-word vocabulary		[ ] No [ ] Yes
36 months	puts on and takes off some clothing, identifies some body parts, jumps up and down		[ ] No [ ] Yes

24. Parenting Education

Do you have a car seat for your child(ren): [ ] No [ ] Yes Do you know how to use it? _____

Education/Classes you have taken:

CPR: [ ] No [ ] Yes When: _____Where: _____

Baby Care [ ] No [ ] Yes When:_____ Where:_____

Parenting [ ] No [ ] Yes When:_____ Where:_____

Toys/Equipment Safety [ ] No [ ] Yes When:_____ Where:_____

Child care needs: _____

How do you play with your baby? _____

How do you comfort your baby? _____

What do you do when your child does something wrong? _____

25. Client's Other Biological Child(ren)

Full Name	DOB	Sex	Birth Wt.	Other Biological Parent	Legal Custodial Parent	Adopted Y/N	Foster Care Y/N

What is/will be the best thing about being a teen parent?_____

What is/will be the hardest thing about being a teen parent? _____

PART VIII
GOALS /SELF-ASSESSMENT

26. Goals and Self-Assessment

	Personal Goals	Educational Goals	Strengths
Client	1. 2. 3.	1. 2. 3.	1. 2. 3.
Case Manager Impressions	Client Strengths: _____ _____ _____	Communication Skills: _____ _____ _____	Receptiveness to Services: _____ _____ _____

	_____	_____	_____